Barchester Healthcare Homes Limited

Ashford House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 08 March 2017 and was unannounced. This was a comprehensive inspection.

Ashford House is a nursing home providing support to up to 54 people. At the time of our inspection there were 47 people living at the home. Most people at the home were living with dementia. Some people also had complex physical health needs.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection was in January 2016 where we identified concerns with medicines management. At this inspection we found actions had been taken to ensure this regulation had been met but we identified one other breach of regulation regarding staff deployment and made a recommendation that communications be improved with people and relatives.

People were not cared for by sufficient numbers of staff. Staff deployment across units meant that on one unit staff were rushed and unable to spend time with people apart from meeting their personal care needs. People waited longer for support and staff were rushed. We observed inappropriate moving and handling techniques used by staff on this unit, despite staff having been trained in these techniques.

People's medicines were administered safely by trained staff. Improvements had been made to record keeping and staff demonstrated competence in handling and administering medicines. Staff worked alongside healthcare professionals to ensure that people's healthcare needs were met.

People were kept safe from abuse as staff understood their role in safeguarding people. Risks to people were assessed and plans were in place to minimise risks to people. Where incidents had occurred, measures were taken to prevent a reoccurrence.

People had access to a wide range of activities, although not everyone we spoke to agreed there was enough to do. The provider was in the process of implementing changes to how activities were provided to people living with advanced dementia. People were provided with a choice of food that matched their dietary requirements.

People were supported by kind and committed staff. People were encouraged to make their own choices and decisions. People's cultural and religious needs were supported by staff. Where people were not able to make decisions, their rights were protected as staff worked in accordance with the Mental Capacity Act 2005.

Staff had input into how the home was run and regular staff meetings took place. People and relatives also

had regular meetings so they could discuss the running of the home. The provider maintained up to date records. People's feedback was regularly sought and where complaints were raised these were dealt with.

Appropriate checks were undertaken to ensure that staff were appropriate for their roles. Staff had access to a range of training and received regular supervision. Clinical staff were supported to keep up to date with good practice.

Systems were in place to reduce the risk of fire and to ensure people's health and safety. A plan was in place to ensure that people's needs would continue to be met in the event of an emergency.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not sufficient numbers of appropriately trained staff deployed to meet people's needs. Following the inspection, the provider increased staffing numbers.

The provider carried out appropriate checks on staff to ensure that they were suitable for their roles.

People medicines were managed, administered and stored safely.

Risks to people were assessed and measures were in place to minimise them.

Staff understood their roles in safeguarding people. Where incidents occurred, these were reported to the local authority.

Accidents and incidents were recorded and actions were taken to prevent them reoccurring.

Is the service effective?

Good

The service was effective.

People were provided with food that they liked, in line with their dietary requirements.

People had access to a variety of healthcare professionals to support their well-being.

People's rights were protected because staff worked in accordance with the Mental Capacity Act (2005). Where restrictions were in place, the correct legal process was followed.

People were supported by staff who had received training and appropriate support to meet their needs.

Is the service caring?

Good

The service was caring.

People were supported by kind staff who knew them well.

Staff asked people's consent and involved them in their care.

People's privacy and dignity was respected by staff.

People's independence was encouraged.

People's cultural and religious needs were met.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities. The provider was in the process of improving activities available to people.

Care plans were person centred and reflected people's needs, preferences and what was important to them.

People's needs were reviewed regularly and any changes in need were met by staff.

Complaints were responded to and actions were taken.

Is the service well-led?

Good

The service was well-led.

Relatives had opportunities to be involved in the running of the home. However, important information was not always passed on.

Systems were in place to monitor the quality of people's care.

The provider kept up to date records.

Systems were in place to pass on important messages to staff. Staff had opportunities to be involved in the running of the home through regular meetings.

Ashford House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 08 March 2017 and was unannounced.

The inspection was carried out by three inspectors, a specialist advisor in nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke to eleven people and three relatives. We spoke to the registered manager, the deputy manager, the clinical lead, the regional operations manager and five members of staff. We observed how staff cared for people and worked together. We read care plans for seven people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at three staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff and residents.

Our last inspection was in January 2016 where we identified concerns with medicines management.

Requires Improvement

Is the service safe?

Our findings

People gave us mixed feedback on staffing levels at the home. One person told us, "I've got enough staff around to look after me." However, a relative told us, "There's not enough care staff. Staff are very stretched and they don't have time to sit and interact with people." Another relative said, "There's not enough staff. (Person) has to wait a long time sometimes."

One staff member told us that at times there were not enough staff to safely meet people's needs. They said that where people needed the support of two staff to mobilise, this was not always possible. There were inconsistencies in the way that staff were deployed around the home. In one unit, we observed that staff were rushed when providing care and people had to wait longer when they needed support. At lunchtime, two people on this unit waited 40 minutes after being seated to be supported to eat their meal. However, in another unit of the home we observed staff responding to people quickly and being able to spend time with people. Staff in that unit told us that they had enough time to support people.

The provider had a tool to calculate staffing numbers. This took into account people's needs, such as when people required two staff to support them. There were more staff present than the tool had calculated as necessary. However, we still observed that in one unit staff were rushing to meet people's needs and did not have time to spend with them apart from delivering their personal care. Relatives and staff told us that there were more staff present there on the day of inspection than they would normally see. One person told us, "We don't normally have all this staff. There's usually about half the number." A relative told us, "It's a bit of a sore point, the shortage of staff. They are meant to have six, but if two call in sick it makes it hard for the others. There are a couple of extra people helping out today." We noted that a clinical audit carried out in February identified that the mix of skills and experience of staff on the unit 'needs to be monitored'. When we highlighted our concern about the staffing of this unit, the provider told us that it was not something they had been aware of. After the inspection, the provider increased the number of staff on this unit to ensure people's needs could be met safely.

We recommend that the provider reviews how they calculate staffing numbers to ensure that sufficient staff are always present to meet people's needs.

We observed three occasions in which inappropriate moving and handling techniques were used by staff. In one instance, staff attempted to move a person using a hoist. The sling used to hold the person was not properly in place. The staff members did not follow best practice in ensuring that the person was secure. The regional manager intervened after two unsuccessful attempts to move the person. The person was not supported in a way that would make them feel safe or preserve their dignity. On two other occasions we observed a staff member using drag lifts to support people to move. A drag lift is where staff pull or drag a person from under their arms. This manoeuvre increases the risk of injury to the person and is not in line with best practice. Staff told us that there had been instances where they had seen inappropriate techniques used. We informed the provider of this and they reviewed the care plan of the person supported to use the hoist. The staff involved then completed refresher training in moving and handling. The provider increased staffing numbers after the inspection. This meant staff would be less rushed when supporting

people to move safely.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. The staff files contained evidence that the provider had obtained a Disclosure Barring Service (DBS) check for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also included proof of staff's identity and references to demonstrate that prospective staff were suitable for employment.

At our inspection in January 2016, important information was missing from people's medicines records. Records were not kept up to date and best practice was not followed in managing medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made the required improvements to medicines management. People told us that they received their medicines safely. One person told us, "I've got a list of what (medicines) I take and they bring them to me." In their PIR, the provider told us that, 'Nurses administer the medication to residents. Medicines are stored correctly, administered and disposed of and accurate records kept.' Our findings supported this. Records of medicines were up to date and accurate accounts were kept. Best practice was followed in the storage and management of people's medicines. Regular audits of medicines took place to ensure standards were maintained. Medicines records stated people's allergies and contained pictures of people. This ensured staff knew who they were administering medicine to. Protocols were in place for homely remedies and PRN (as required) medicines. A relative told us, "They watch (person) and know best when to give the medication." Records showed PRN medicines were being administered appropriately. A recent report by the provider had noted a decrease in the use of some medicines, linked to people's behaviour. This demonstrated that staff were using practical interventions with people and only using medicines where these had not been successful.

Staff kept medicine administration records (MARs) up to date. Where medicines had not been administered, staff completed records stating the reason. Staff had been trained to manage medicines and they were required to pass a competency test before administering people's medicines. This demonstrated that the provider made sure that staff who administered medicines were skilled and competent enough to do so. We observed medicines being administered. Staff did this carefully and ensured administered medicines were accurately recorded. Medicines were stored safely in locked cabinets or a medicines fridge where necessary.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Care records contained clear risk assessments that had been regularly reviewed and risk management plans were in place to keep people safe. One person living with dementia could sometimes become aggressive and behave in a way that could upset other residents. A risk assessment identified this and measures to keep them safe were in place. Staff monitored the person regularly and diverted their attention if they were becoming agitated. The person used to have a favourite pet that staff talked about with them. This information was clear for staff. Staff demonstrated a good understanding of how to support this person if they became unsettled. Another person was assessed as at risk of pressure sores. They were repositioned regularly and staff monitored their skin and applied creams where necessary. When changes were identified, staff alerted healthcare professionals quickly.

People were protected against the risks of potential abuse. Staff demonstrated a good understanding of safeguarding procedures and knew their role in protecting people. One staff member said, "I'd speak to the manager. I could also call the police or speak to CQC." Staff had been given training in safeguarding.

Safeguarding incidents were being referred to the local authority and notifications were being sent to CQC. People and relatives were given information on how to stay safe and how to contact outside agencies if they were concerned about their safety.

Accidents and incidents were documented and staff learnt from these to support people to remain as safe as possible. There was an accidents and incidents log that included a record of all incidents, including an analysis and outcome which recorded what had been done to prevent the same accident happening again. One person had fallen at night twice within two days. Both times staff ensured that the person was safe and put measures in place to prevent further falls. Staff increased nightly checks of the person and a sensor mat was put in place to alert staff if the person got out of bed. Staff could then support them to move safely. With these measures in place, the person suffered no more falls.

People could be assured that in the event of a fire staff had been trained and knew how to respond. Staff were able to explain what action they would take. There were individual personal emergency evacuation plans (PEEPs) in place that described the support each person required and these had been reviewed to make sure they reflected people's current needs. We did note that protective equipment was not available to people who smoked. We informed the provider of this. Following the inspection, they submitted evidence to us to show this improvement had been made.

Good

Is the service effective?

Our findings

People told us that they were happy with the food on offer at the home. One person told us, "The food is very good here." A relative told us, "The food is very good." Another relative said, "There are two choices of pureed main and vegetables."

People were provided with meals in line with their dietary requirements and preferences. In their PIR, the provider told us that, 'The chef has monthly nutritional meetings with the nurses to keep up to date with residents changing nutritional needs and preferences. Meal times are a pleasant experience with choices of menu and food cooked to cater for different dietary requirements and textures.' Our findings supported this. Apart from where we reported in the Safe domain that people in one unit waited for 40 minutes for help to eat, people's mealtimes were pleasant. People's records contained information on what they liked to eat. One person liked liver and bacon. This was in their records and this had been included in the menu. People were offered a choice at mealtimes and people could request a freshly produced alternative from the kitchen. People were shown food options at mealtimes so that they could make an informed choice. The provider regularly sought feedback regarding the food and we observed staff asking people if they enjoyed their meals.

The provider had introduced a 'one home' approach to meal times. This meant that non-care staff supported people to eat. These staff had been provided with basic training in 'dementia care awareness'. They had also completed e-learning for choking awareness. The provider introduced this approach as a way to create an inclusive atmosphere at mealtimes. This was because people and staff sat together to eat. The registered manager told us that this support from non-care staff was optional. However, we were told that non-care staff felt pressured to support at mealtimes due to staffing numbers. They told us that they did not feel equipped to support people to eat with the training that they had been given. We highlighted our concern to the provider after the inspection. The provider increased staffing numbers on one unit and reviewed staff training.

Where people had specific dietary requirements, these were met by staff. Most people at the home were living with dementia. Staff had received training in how to maintain people's nutrition where they were living with dementia. They told us, "We don't assume someone is done because they have stopped eating. Also we sometimes use finger foods and smaller portions to make the eating easier." Staff had noted one person was having problems swallowing food. Staff referred them to a speech and language therapist (SALT). The SALT recommended that they eat pureed food to reduce the risk of choking. The person's care plan was updated and they were provided with food in line with this guidance. People were weighed regularly and their food intake was recorded. This enabled staff to identify any changes in the person's health and refer them to healthcare professionals as required. A recent audit by the provider identified that 60% of people living at the home had seen increases in their weight which demonstrated their nutritional needs were being met.

People told us that they had access to healthcare professionals. One person told us, "I can see the doctor whenever I need." Staff told us that they had a good relationship with the GP. Where people had become unwell, they were seen by healthcare professionals quickly. One person had developed pain in their leg.

They were seen by the GP and referred to a physiotherapist. They were prescribed medicines and their care plan was updated so that staff were aware of the person's leg pain when supporting them. Another person living with dementia had a history of incidents which presented a challenge to staff. They were referred to a local 'intensive support team.' They worked closely with the person and staff. Staff provided information on the person's mood and behaviour to the team. This helped them to identify approaches that would support this person safely. Since this involvement, there had been a reduction of incidents involving this person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff were following the correct legal process. After our last inspection, we recommended that the provider ensured all the correct legal documentation was in place. At this inspection, we found decision specific mental capacity assessments were completed before best interests decisions were made. Records contained the correct documentation. One person received their medicines discreetly in their food. A mental capacity assessment had established that they were unable to make the decision to take their medicines themselves. A doctor, pharmacist, staff and relatives were involved in making the best interest decision to administer medicines covertly, in the person's best interests. Where restrictions were required an application was made to the local authority. Staff had been provided with training in the MCA and demonstrated a good knowledge of how it worked in day to day practice.

People were supported by staff who had the appropriate training to meet their needs. One staff member told us, "We complete a lot of training. I found the dementia training really useful." Staff training included safeguarding, health and safety, moving and handling and the Mental Capacity Act (2005). All staff completed the care certificate. The care certificate is a set of national standards in adult social care. Staff also received training in supporting people with dementia. The provider was implementing a programme of good practice in dementia care. As part of this, staff were receiving ongoing training and support to develop good practice in dementia care. Staff received regular supervision in which they discussed their work and identified any training they wished to pursue. Records of supervision meetings showed that staff discussed good practice, as well as any training requirements. Staff also received regular appraisals where they could discuss their performance and any areas for development.

Good

Is the service caring?

Our findings

People told us that they thought that staff were caring. One person told us, "They are so kind." Another person said, "There are some good carers who have a handle on (person), so that is nice. The carers work extremely hard." A relative told us, "It's a nice place. The staff are caring and attentive."

People were supported by kind and caring staff. Our observations of caring interactions throughout the day showed that staff were caring and committed to people. Staff spoke to people warmly and took an interest in them. Despite staff on one unit being rushed at times, they maintained a friendly and caring demeanour with people. In another unit, staff spent time reading books and newspapers with people. People and staff shared jokes and there was a warm atmosphere in the communal areas. Staff were smiling and appeared to enjoy their work. Cleaning staff and kitchen staff were observed smiling and engaging with people. In one instance, we observed staff working with relatives to assist someone to make a choice about what they wanted to eat. This demonstrated that there was a friendly and inclusive environment within the home.

People were supported by staff that knew them well. Staff were knowledgeable about people's preferences and life histories and the information they told us clearly matched with the information recorded in people's care records. A staff member told us, "I talk to people mostly, but we must always look at the care plans. I like learning about their lives." People's care records contained life histories. One person had an interest in sport, this was clear in their plan and staff knew this about them. Another person's records stated, '(Person) has strong family values. Family always comes first.' We observed staff talking to this person about their relatives who had visited recently.

People told us that staff always sought consent and involved them in their care. One person told us, "They (staff) don't do things without my say so." In their PIR, the provider told us that, 'Staff obtain verbal consent before any task and maintain privacy. If residents are unable to give consent staff explain what they are going to do and talk to the resident as they go through the procedure.' Our findings supported this. We observed staff interacting with people in a way that involved them. People were offered choices and staff asked people's consent before providing care. Staff demonstrated a good understanding of how to involve people. One staff member told us, "I always ask what they want to wear." Another staff member said, "Even if people have advanced dementia, they still know what they like so we ask."

Staff supported people in a way that promoted their privacy and dignity. Staff had undergone 'Care Experience Training'. This training focussed staff on how it feels to be in receipt of care. This was designed to promote awareness of people's dignity and how staff can respect it. Where people needed support with personal care, we observed staff handling this discreetly and sensitively. Staff demonstrated a good understanding of how to provide care in a way that maintained people's privacy. One staff member told us, "I knock before I enter and make sure doors are closed. I talk people through what I'm doing and ask them if they're comfortable."

People were provided support in a way that promoted their independence. People's care records contained information on what they were able to do themselves. This meant that staff could provide support where it

was needed, whilst allowing people to complete tasks that they were able to. One person was able to carry out some personal care tasks themselves. Their care plan made this clear and staff knew this person's strengths. Staff demonstrated a good understanding of how to encourage people to be independent. We observed people preparing drinks either on their own, or with staff support. At mealtime, people who were able to eat independently were enabled to do so.

People's cultural and spiritual needs were met. One person told us, ""Ministers come to give communion on a Friday; a catholic one and a church of England." People were asked about their religion and culture when moving into the home and where people had needs these were met. One person's records said that they were a Christian. They told us that they were visited regularly by a minister. Staff knew about this person's faith and they told us they supported other people to meet their spiritual needs.

Good

Is the service responsive?

Our findings

People gave us mixed feedback about the activities that were on offer. One person told us, "I do what I want to do. I wouldn't want to go anywhere else." However, another person told us, "There's not a lot of entertainment here; we could do with a bit more." A relative said, "The activities are poor. They have live entertainment, but it seems the more capable people get the activities. They used to do cooking."

People had access to a range of activities. Activity timetables were on display in the home. There were games, quizzes, films, visits from entertainers and arts and crafts. Records contained information on people's interests and what types of activities they enjoyed and these were included in the timetable. One person's care plan stated that they enjoyed art and painting. There were a number of arts and crafts activities for them to participate in. We observed staff arranging flowers with some people. They told us that it was a hobby of theirs and they enjoyed flower arranging regularly at the home.

We did receive some negative feedback regarding the range of activities that were on offer. This feedback came from people and relatives on the unit where we found staff were too rushed to provide interaction beyond the delivery of personal care. We did observe less one to one interaction with people on this unit. Group activities did take place here. We observed people participating in a music activity and it created a lively atmosphere. However, there were people on the unit with complex needs who were less able to participate in group activities. Staff told us they had less time to interact with people and provide them with social stimulation and physical activity. The home employed two activity co-ordinators, one of whom worked part time. After the inspection, the provider increased their hours to full time. This was so one activity co-ordinator could support people with higher needs. The provider had developed a scheme of good dementia practice which was called the '10.60.06' scheme. This holistic scheme looked at areas such as the home environment, staff training, nutrition and personalisation for people living with dementia. As part of this scheme, an audit had identified more needed to be done to involve people living with dementia in choosing activities. At the time of our inspection, the scheme had not been fully implemented but the provider was working towards this. We will follow up on what impact the scheme has had on people living with dementia at our next inspection.

People's care plans were personalised and information on what was important to them was clear. Records contained information on what support people needed from staff to meet their needs, as well as their preferences and daily routines. One person was living with dementia. They were not able to leave the home unaccompanied but often became distressed when they thought about their previous home. Their care records stated that when they became upset, staff should support them to walk around the gardens as they liked the outdoors and wildlife. We observed this person being supported to use the garden by staff and staff had an understanding of their needs when we spoke to them. Another person living with dementia sometimes became agitated during personal care. Their records were clear, stating that if they started to become aggressive then staff were to stop and allow them time before coming back later to ask if they wished to receive care.

People received a thorough assessment before coming to the home to ensure that their needs could be met.

Assessments captured information about people's needs as well as their backgrounds and lifestyles. In their PIR, the provider told us that, 'Relatives and residents where they are able, are involved in care plan reviews. We have a resident of the day system in place as well as key workers and named nurses.' Our findings supported this. People received regular reviews to identify if their needs had changed. People and relatives were involved in assessments and reviews and information from healthcare professionals was sometimes provided to help identify changes. One person's review had identified that their mobility had declined. This prompted their risk assessments to be updated and an increased risk of pressure sores was identified. Measures were put in place to manage this risk.

People told us that they knew how to make a complaint. One person told us, "I have no problems at all. I'm quite happy. I would complain if I wasn't." The complaints policy was visible within the home. Staff told us that they would report complaints to the manager or senior staff. Complaints were documented and responded to. There had been four complaints since our last inspection. The provider was dealing with an ongoing complaint when we visited. This involved the local authority. We saw evidence that information was being provided as requested to try to reach a resolution for the person and their relatives.

Good

Is the service well-led?

Our findings

Relatives told us that they felt communication could be better. One relative told us, "There is no communication. (Registered manager) is lovely but does not have enough control over staff." A staff member told us, "Communication is terrible. Relatives are always complaining that they have not heard back or are not told things."

Issues raised by people and relatives at meetings were not always actioned. One relative told us, "The last meeting turned into chaos. Everyone was talking over one another. Suggestions we make aren't acted on." Minutes of a meeting in December showed that relatives had raised communication as an issue. They had stated that bathroom cabinets were not the right size to fit items in. Management were planning to update these following refurbishment works, but relatives told us that they had not been told when work would be completed. As part of the '10.60.06' project, memory boxes had been moved from outside people's rooms to inside which made them more accessible for people. One relative told us that they did not feel they had been consulted. Memory boxes were replaced with decoration and pictures to fit certain themes in areas of the home as part of the scheme. Themes consisted of areas of interest such as films and music. Relatives had raised this at a meeting. Relatives told us that they did not feel they had been kept up to date on the '10.60.06' scheme and changes to the home environment that were taking place as part of it.

We recommend that the provider reviews their systems of communication with people and their relatives.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The registered manager carried out regular audits and documented their findings and any actions taken. These covered areas such as the housekeeping, laundry and kitchen. The home environment, including health and safety and fire, were audited frequently. The provider visited regularly to undertake their own audits. Where improvements were identified, these were actioned by staff. A recent provider audit had identified that some relatives had not been consulted about people's care plans. Letters were sent to relatives in order for them to discuss care plans with staff. Accidents, incidents and complaints were recorded electronically. The provider regularly analysed these to identify patterns or areas for improvement. The provider sent out surveys to ask people and relatives for feedback. The latest survey was in progress at the time of our inspection.

The provider kept up to date and accurate records. Records were regularly audited and the information in care records was clear and up to date. The provider kept to timescales for audits and reviews and information was recorded quickly. Staff told us that they had time to record daily entries in people's records and we observed them doing so on the day of our inspection.

At the time of our inspection, refurbishment works were underway to improve the home environment. The provider had completed appropriate risk assessments for the refurbishment works. People's wishes were taken into account during the works. Most people had moved to another unit whilst works are carried out. Where people had not wanted to move, support was put in place to enable them to remain in their rooms whilst work was completed. We will review how the refurbishment works have improved the home

environment at our next inspection.

Systems of communication were in place between staff and management. In their PIR, the provider told us that, 'Stand up meetings are held at 11am each day, with the heads of departments. The heads of departments feedback any relevant information to the rest of the staff.' Our findings supported this. Staff told us that information was passed to them following daily meetings. Staff meetings also took place regularly. This provided staff with an opportunity to have their say about any concerns they had or how the home could be improved. One staff member told us, "We can say things in meetings. They are also important times for us to hear about changes and share information." Minutes of meeting showed they were used to discuss people's needs, as well as to talk about good practice and changes at the home.

The registered manager was aware of their responsibilities. Registered bodies are required to notify us of specific incidents relating to the home. We found when relevant, notifications had been sent to us appropriately. For example, in relation to any serious accidents or incidents concerning people which had resulted in an injury.